CUMSTON (C. G.)

DOSAGE OF HEMOGLOBIN IN GYNÆCOLOGICAL CASES.
BARTHOLINITIS. POSTERIOR VAGINAL CŒLIOTOMY.
MEDICAL TREATMENT OF DYSMENORRHŒA.
SURGICAL TREATMENT OF PROLAPSUS UTERI.

Notes from the Gynæcological Clinic of

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Dosage of Hemoglobin in Gynæcological Cases. Bartholinitis. Posterior Vaginal Cœliotomy. Medical Treatment of Dysmenorrhœa. Surgical Treatment of Prolapsus Uteri.

(NOTES FROM THE GYNÆCOLOGICAL CLINIC OF DR. CUMSTOM. REPORTED BY L. F. G.)

The importance of knowing the per cent. of hemoglobin, as well as a blood count, to ascertain the condition of the blood in surgical and gynæcological cases is not generally recognized by surgeons.

Dr. Cumston resorts to blood examination in many cases, both surgical and gynæcological, especially where operative interference is indicated. He considers Gower's hemiglobinometer as very satisfactory and sufficiently exact for all practical purposes. In cancer, the per cent. of hemoglobin is nearly always low, reaching even to fifteen per cent. in a case which the professor had seen. Exceptions to the rule occur, however, and a patient with carcinoma of the splenic flexure of the colon, on which Dr. Cumston had recently operated, had blood containing eighty-nine per cent of hemoglobin. A fair prognosis was made as to the lease of life in this case on acconnt of the good condition of the blood, and in fact the patient survived over six months the operation. Nothing radical could be done, as the incision showed that the mesentery was riddled with infiltrated glands.

There was one fact not to be forgotten. In cases in which there is a complete obstruction of the ductus communis choledochus, with resulting retention of the bile and its pigments, the latter accumulated in the liver, where they destroyed the hemoglobin, which was eliminated in the form of biliary pigment.

The result of this destruction of hemoglobin would be a very low per cent. when examined.

A patient was then shown with carcinoma of the cervix, not very advanced, but invading the vaginal walls, thus contra-indicating any radical operation. The patient, aged forty-seven, was not cachectic. Hemiglobinometer showed the per cent. of hemoglobin to be thirty-five, and an early cachexia with death was predicted by the professor.

A case of abscess of the vulva-vaginal gland in a woman aged twenty-four was next shown. This disease is called bartholinitis by Dr. Cumston, and he considers it an inflammatory

process ending in either a canalicular or parenchymatous abscess of the vulva-vaginal gland.

The affection is always due to a pus-producing organism, but *may* occur without gonorrhœal infection; the gonococcus is consequently not the *specific* microbe of this particular abscess.

The etiology of this affection is very often a gonorrhœal infection, but usually there is a *mixed* infection of the gonoccocus and staphylococcus. The former organism prepares the soil for the latter, so that when the pus from these abscesses is examined bacteriologically only the staphylococcus is to be found, Neisser's organism having disappeared.

The pathological anatomy, according to Dr. Cumston, is as follows: Considerable epithelial proliferation in the excretory ducts; embryonic cell infiltration extending around and along the ducts; the formation of pericanalicular abscess explain the pathogenesis of the relapsing form of this affection so frequently met with.

As to treatment, a simple abscess of the gland should be incised. When the affection is chronic the gland should be extirpated with all aseptic precautions.

A patient presenting an enlarged tender ovary, prolapsed and adherent in the left vaginal cul-de-sac, was then brought before the class, and after discussing the symptoms and diagnosis, Dr. Cumston said that posterior vaginal cœliotomy was a most logical and direct way for unilateral extirpation of the diseased adnexa, as in the case under consideration. The operation in no way changes the static conditions of the uterus.

The modus operandi is not complicated, although complete bilateral extirpation is not easy. The posterior incision was in the majority of cases superior to anterior colpotomy.

The vaginal route was decidedly indicated for the removal of small tumors, and in such cases was far less difficult than laparotomy. The formal indications of posterior vaginal cœliotomy were, *the small size of the diseased organs, their mobility, unilateral lesions, the possibility of lowering the uterus to render the adnexa easy of reach to the fingers* and instruments.

The contra-indications were a large sized mass, immobilty, many adhesions, fixed position of the adnexa in front of the broad ligament in the prevesical fossa.

In all operations performed for pelvic trouble, Dr. Cumston insists on trying to render the intestinal tract aseptic. For this naphtol B, 20 centigrammes in a cachet after each meal, or creolin formulated as follows were recommended:

℞	Creolin.	6.0
	Alcohol. dil.	1.0
	Ext. liquirit.	
	Pulv. liquirit.	aa 6.0
	Gum. adragant.	1.0

m. f. s. a. pil. no. C.
D. S. Take one pill four times daily.

Dhysmenorrhœa in well-developed, non ænemic women, where after careful bimanual examination no inflammatory process is to be found in either the uterus or adnexa, viburnam pruni-

folium will give very excellent results.

In ovarian dysmenorrhœa, when the flux is scanty and functional development delayed, the exhibition of iodide of soda, combined with nux vomica and iron, is indicated.

Dr. Cumston thinks that antipyrine is of considerable value in certain cases of this disorder of the menstruation, at the dose of from two to four grammes in twenty-four hours or combined with the bromides, the following formula being given as an example:

℞ Antipyrini. 10.0
Ammon. bromid.
Kalii bromid. aa 5.0
Ext. vibur. prunifol. fld. 20.0
Spir. vini gallici.
Syr. cort. aurant. aa 40.0
Aq. dest. 60.0

M. D. S. Take a teaspoonful four or five times daily.

A most important point in treatment is to keep the bowels open, and Carabana water, at the dose of a wineglassful before breakfast, was most highly recommended. Those patients who could not afford the water were to take the following:—

℞ Pulv. jalap. 10.0
Pulv. rhei.
Oleosacch. limonis. aa 5.0
Sulphur. præcip.
Kalii bitartrat. aa 20.0

M. D. S. A teaspoonful in a glass of water, to be taken in the morning.

Dr. Cumston also impressed forcibly upon the class that morphine or the preparations of opium were to be avoided in the relief of pain, which can be very well controlled by a suppository composed as follows, recommended by Farlow:

℞ Ext. belladon.,
Ext. cannabis indicæ, aa 0.02
Ol. Theobrom. q. s. ut f. supposit. no. I. D. tal. dos. no. X.
D. S. Insert one suppository every night and morning if necessary.

Another excellent formula much relied on by the professor was:

℞ Ext. belladon. 0.01
Pulv. nuc. vom.
Ferri reduct. aa 0.02
Ext. cinchonæ q. s. ut f. pil. no. I. D. tal. dos. no. xx.
S. Take one pill three or four times daily.

When the patient showed signs of hysteria, a pill containing camphor was of service.

℞ Pulv. camphor. 0.10.
Res. asafœtid. 0.05.
Ext. gentian. q. s. ut f. pil. no. I.
D. tal. dos. no. xxx.
S Take five or six pills a day.

Medical treatment also included electricity, massage and a proper hygiene, the latter should never be overlooked.

Dysmenorrhœa in the vast majority of cases was only a *symptom* of some gynæcological affection, such as perimetritis, metritis, the various deviations of the uterus, salpingitis, ovaritis or cystic degeneration of the ovaries, as well as stenosis of the cervix, all of which required a proper surgical interference.

In closing, the professor said that he desired to point out how necessary it was for the surgeon to be familiar with the materia medica and to know

how to prescribe, an accomplishment which was rarely seen in these days of compressed tablets, and also the fact that just because a woman complained of some pain or inconvenience in the genital organs it was not necessary for the young professional man to consider his patient as subject for operative surgery.

Many cases of dysmenorrhœa were successfully treated medically, and the tendency of the day was to submit women to many needless operations, although it was to be distinctly understood that many conditions could only be releived or cured by the knife in the hands of a man posessed with a profound knowledge of the technique and indications of the current gynæcological operations.

The surgical treatment of prolapsus uteri comprised four operations, viz: *plastic operations* on the vaginal walls and perineum; *Alexander's operation*; *hysteropexy*; *vaginal hysterectomy.*

Prolapsus of the uterus was produced by two kinds of anatomical conditions, viz: (1) insufficiency of the means of suspension of the uterus; (2) a relaxed condition of all the soft parts which make up the pelvic floor, that is to say, the vagina and perineum.

Slight prolapsus should be treated by anterior colporraphy combined with posterior colpoperineorraphy. When the uterus was hypertrophied, amputation of the cervix should also be performed.

Complete prolapsus was not cured by hysteropexy, according to the experience of Dr. Cumstom. This operation was serious, as the peritoneal cavity was opened, a fact that was treated too lightly by many operators.

As to vaginal hysterectomy for prolapsus, it was only to be performed in cases in which the parts had become strangulated and could not be reduced, or if gangrene had set in from the strangulation. When a uterus, having a fibroid, prolapsed, vaginal hysterectomy was indicated, not for the prolapsus but for the neoplasm.

If vaginal hysterectomy is resorted to in cases of prolapsus, the operation should *always* be completed by a resection of the vagina and posterior colpoperineorraphy.

Regarding Alexander's operation, it was only of use when the uterus was *small* and for this reason it was often successful in prolapsus in old women. But even in these cases, anterior colporraphy and perineorraphy should be performed.

No matter what operation was selected as proper for the particular case, it was to be remembered that a plastic operation on the vaginal walls and perineum should always be performed if complete success was to be attained.